STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86276-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 28th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 13, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it for external review on November 20, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on November 30, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). Rider CBD $500-P, Community Blue Deductible Requirement for Panel Services, also applies. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical

opinion from an independent review organization.

II
FACTUAL BACKGROUND

On August 22, 2007, the Petitioner, who lives in XXXXX, purchased a walker from the XXXXX, a panel provider with the Anthem Blue Cross and Blue Shield plan in XXXXX (Anthem). The shop filed a claim with Anthem using procedure code E0143, the code for a basic standard walker. Anthem approved a payment of $83.69, its maximum amount for a standard walker. BCBSM applied this amount to the Petitioner's $500.00 deductible for panel services.

The Petitioner appealed BCBSM's failure to pay for her walker. BCBSM held a managerial-level conference on October 26, 2007, and issued a final adverse determination dated October 30, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the walker provided to the Petitioner by XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says BCBSM was called before she purchased her walker. The walker was to have a seat, wheels, and a brake. She says BCBSM advised her she had a $100 deductible and a 20% copayment, and suggested that she would be required to pay $126.00 for this type of walker.

On August 22, 2007, the Petitioner purchased a Rollator model walker with an initial payment of $126.00. After Anthem was billed, it indicated that the maximum amount that it would pay for a walker is $83.69. The Petitioner believes that she was misinformed by BCBSM about the amount to be paid for her walker and wants BCBSM to pay more for the device.

BCBSM's Argument

BCBSM says its contracts do not guarantee that charges will be paid in full. Its payment for durable medical equipment (DME) is based on its "approved amount" for that equipment. In this case, since the provider is in XXXXX and participates with Anthem, reimbursement is based on Anthem's approved amount for a standard walker ($83.69), not BCBSM's approved amount. BCBSM applied the $83.69 to the Petitioner's $500 deductible as required in Rider CBD $500-P.

BCBSM says the Petitioner's husband called its customer service operation on July 11, 2007, and was informed about DME providers in XXXXX County where the Petitioner lives. BCBSM says he was also told that the $500.00 deductible applies even if the DME item is purchased from a network provider. BCBSM says there was no mention that the walker would be purchased in XXXXX.

On September 26, 2007, after the walker had been purchased, BCBSM says the Petitioner's husband called again. BCBSM told him that it called XXXXX and was told that the $126.00 initially paid by the Petitioner was the difference between the cost of a standard walker and the deluxe walker that the Petitioner received.

BCBSM says that the certificate covers only standard, not deluxe, walkers. BCBSM says that the information given to the Petitioner and her husband was accurate and not misleading. BCBSM believes that it is not responsible for any additional payment to the Petitioner for her walker.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for services and equipment. The approved amount is defined in the certificate (page 7.2) as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." For covered services received in other states, payment is limited to the approved amount of the local BCBS plan if the provider participates in that out-of state BCBS plan.

Rider CBD $500-P, which is part of the Petitioner's contract, requires the payment of a $500 annual deductible for most covered services from panel providers before BCBSM begins its

payments. The Petitioner has not alleged that the $500.00 deductible had been met for 2007 before she purchased the walker. The Commissioner notes that the Petitioner says she was told she had only a $100.00 deductible; BCBSM disputes this. In any event, the Petitioner's benefit plan requires a $500.00 deductible for most panel services including walkers.

Section 5 of the certificate sets forth how durable medical equipment is paid. It indicates (on page 5.3) that BCBSM does not pay for deluxe equipment. The Petitioner purchased a deluxe walker from an XXXXX provider that participates with an XXXXX BCBS plan. The Convalescent Shop filed a claim with Anthem using procedure code E0143, the code for a standard walker. Anthem's maximum payment level for a standard walker is $83.69. Anthem would have paid that amount to XXXXX if the Petitioner's deductible had been satisfied and then been reimbursed by BCBSM.

However, Rider CBD $500-P imposes a $500.00 annual deductible on panel services. Since the Petitioner had not satisfied the deductible for 2007, BCBSM correctly applied the $83.69 approved amount to the deductible. The Petitioner is also responsible for any difference between the $83.69 applied to the deductible and the actual cost of the deluxe walker.

The Petitioner believes that BCBSM misinformed her about the amount it would pay for her walker. BCBSM denies that it misinformed her and says that its customer service records reflect that accurate information was given. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. The Commissioner cannot resolve the kind of factual dispute described by the Petitioner because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on oral statements, and furthermore, the Commissioner is without authority (which the circuit courts possess) to order equitable relief.

The Commissioner finds that BCBSM has correctly applied the provisions of the Petitioner's certificate and applicable rider.

V
ORDER

BCBSM's final adverse determination of October 30, 2007, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's walker.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.